STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 French Landing, Suite 300
Heritage Place Metro Center
NASHVILLE, TENNESSEE 37243

TENNESSEE BOARD OF OCCUPATIONAL AND PHYSICAL THERAPY
COMMITTEE OF PHYSICAL THERAPY
(615) 532-3202 OR 1-800-778-4123
www.tennessee.gov

APPLICATION INSTRUCTIONS FOR CERTIFICATION AS A PHYSICAL THERAPIST AND PHYSICAL THERAPIST ASSISTANT LICENSURE APPLICATION CHECK SHEET

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a Tennessee license to practice physical therapy. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Committee.**

1.	Complete, sign and have notarized the application pages 1 through 6. (Only page 6 of the application must be notarized.)	_____
2.	Attach a recent, full-faced, passport type photograph to the application. Computer generated images are not acceptable.	_____
3.	Determine the correct amount of fees to be paid according to the fee schedule. Attach check or money order for the proper amount made payable to the State of Tennessee.	_____
4.	All applicants must submit an original letter of recommendation attesting to their good moral character. This letter must be from a Physical Therapist or Physical Therapist Assistant licensed in the U.S. (This letter cannot be from a relative.)	_____
5.	You must have your scores reported by the FSBPT Score Transfer Service if you have previously passed the National Physical Therapy Examination by Tennessee standards. Exams taken prior to July 12, 1995, will be based on the norm referenced scoring method. All exams taken July 12, 1995 and after, will be based on the criterion referenced scoring method. Please visit www.fsbpt.org to order the score transfer or call 703.299.3100.	_____
6.	An exam test history is required for all applicants who are applying to sit for the National Physical Therapy Examination (NPTE) in Tennessee who are **not** new graduates. A new graduate is someone who has graduated/completed all requirements for their degree within the last thirty (30) days. If you are applying to sit for the exam in Tennessee and your graduation date was greater than thirty (30) days ago, please contact the FSBPT regarding obtaining the **"NPTE Test Verification History Service"** form. This form is **not needed** for applicants who have previously **passed** the examination by Tennessee standards.	_____

7.	You must have your school send official transcripts that show degree awarded. If you have **completed** all the requirements for your degree and your diploma or transcripts are not available, you can have the Program Director of the school send verification that all requirements for your degree have been completed. This will enable you to be deemed eligible for the exam. The school must submit official transcripts that confirm the degree has been awarded before permanent licensure can be granted. Transcripts must come directly from the school to the Committee's Administrative Office. Please complete the **"Education Verification"** (Attachment 1) form to have the school send official transcripts. If you are not sure if your school's PT/PTA Program is a CAPTE Accredited Program, contact the school or the American Physical Therapy Association (APTA) for this information.	_____
8.	If you hold or have ever held a certificate/license/permit to practice any profession, complete the **"Verification from Other State Certification Boards"** form (Attachment 2) and send to each state where you have ever held certification, licensure or permit.	_____
9.	Documentation submitted to the Committee by International graduates that is not written in English must have an English translation. The English translation of the documents must be certified.	_____
10.	International Graduates must have a "Comprehensive Credential Evaluation Certificate for the Physical Therapist" from the Foreign Credentialing Commission on Physical Therapy (FCCPT) submitted directly to the Committee from the FCCPT. FCCPT 509 Wythe Street Alexandria, VA 22314 (703) 299-3100 www.fsbpt.org Please note that all International Graduates will be required to complete a 480 hour internship after educational credentials have been approved.	_____
11.	All exam applicants can register to take the exam at www.fsbpt.org. International Graduates should not register for the exam until after the Committee's approval of educational credentials.	_____
12.	If you are applying for a license as a Physical Therapist only you must complete and return the enclosed "Mandatory Practitioner Profile" before a license can be granted.	_____
13.	If you wish to obtain certification to perform EMG's please refer to Rule 1150-1-.04(4) for requirements.	_____

UNDERSTANDING THE APPLICATION PROCESS

If an address change occurs <u>at any time, you must</u> notify the Board office, in writing, immediately.

1. All application fees are non-refundable.

2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

Committee of Physical Therapy
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243

For Federal Express or Special Courier:
Committee of Physical Therapy
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243

3. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Federal Express or special courier services <u>will not</u> appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used you <u>will</u> be responsible for charges incurred. The Board asks that you please give the Board office every consideration in this matter.

4. **We will discuss application status with the applicant, applicant's spouse or to whom ever may hold power of attorney <u>only</u>.** Please inform hospitals, employers, recruiters, referral companies or insurance companies that application status updates must be obtained from the applicant. Status information will be mailed to the address listed on the application.

5. If necessary documentation has not been received when your application has been received by the Board office, an initial deficiency letter will be sent to you by mail.

6. **Absent any complicating factors, <u>the average application processing time is six weeks</u>. Once the application is completed, your file will be promptly reviewed and an initial licensure determination made. You will be promptly notified by letter of the initial determination.**

7. If you are taking an exam in Tennessee the average time for receipt of scores from the FSBPT is three to four days. An additional week (1) is required by our office for processing. Exam information (i.e. scores, pass, fail) <u>will not</u> be given over the phone.

8. It is recommended that you <u>do not</u> make arrangements to accept employment as a Physical Therapy Practitioner in Tennessee until you are granted a license by t he Committee of Physical Therapy.

Thank you for your cooperation. We will make every effort to expedite your application in an efficient manner.

IMPORTANT: You must have a Tennessee License from the Committee in your possession before you may lawfully practice as either a Physical Therapist or Physical Therapist Assistant.

ATTACH A CURRENT FULL-FACE PHOTOGRAPH

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 French Landing, Suite 300
Heritage Place Metro Center
NASHVILLE, TENNESSEE 37243

BOARD OF OCCUPATIONAL AND PHYSICAL THERAPY EXAMINERS,
COMMITTEE OF PHYSICAL THERAPY
LICENSURE APPLICATION
800-778-4123 or 615-532-3202

Choose the appropriate licensure category and method for which you are applying. See the Practice Act and the Rules and Regulations to determine the requirements for each category of practitioner.

LICENSURE ALTERNATIVES

A. _____ Physical Therapist License

_____ Reciprocity from another state
_____ Examination

B. _____ Physical Therapist Assistant License

_____ Reciprocity from another state
_____ Examination

PERSONAL INFORMATION

PLEASE PRINT IN INK

Name: _____
Last First Middle Maiden

Social Security Number: ____ - ____ - ____ Date of Birth: _____

Mailing Address: _____ County (TN Applicants Only): _____
_____ Phone: Home: (____) ____ - _____
_____ Office: (____) ____ - _____

Place of Birth: _____ Sex (optional - for statistical purposes only)
Female _____

U.S. Citizen: Yes _____ No _____ Male _____

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond junior high or middle school. Use the back of this page if you need additional space.

From: ________ To: ________ ______________________________
Mo/Yr Mo/Yr Educational Institution (Physical Therapy) Degree Awarded

From: ________ To: ________ ______________________________
Mo/Yr Mo/Yr Educational Institution Degree Awarded

From: ________ To: ________ ______________________________
Mo/Yr Mo/Yr Educational Institution Degree Awarded

From: ________ To: ________ ______________________________
Mo/Yr Mo/Yr Educational Institution Degree Awarded

Please complete your entire employment history (relating to physical therapy) starting with the most current position first. Use the back of this page if you need additional space.

DATES **LOCATION** **POSITION AND DUTIES**

From: ________ To: ________ ______________________________
Mo/Yr Mo/Yr (City/State)

From: ________ To: ________ ______________________________
Mo/Yr Mo/Yr (City/State)

From: ________ To: ________ ______________________________
Mo/Yr Mo/Yr (City/State)

From: ________ To: ________ ______________________________
Mo/Yr Mo/Yr (City/State)

From: ________ To: ________ ______________________________
Mo/Yr Mo/Yr (City/State)

From: ________ To: ________ ______________________________
Mo/Yr Mo/Yr (City/State)

From: ________ To: ________ ______________________________
Mo/Yr Mo/Yr (City/State)

From: ________ To: ________ ______________________________
Mo/Yr Mo/Yr (City/State)

From: ________ To: ________ ______________________________
Mo/Yr Mo/Yr (City/State)

From: ________ To: ________ ______________________________
Mo/Yr Mo/Yr (City/State)

From: ________ To: ________ ______________________________
Mo/Yr Mo/Yr (City/State)

LICENSURE INFORMATION

List below **ALL STATES, COUNTIES OR PROVINCES IN WHICH YOU HAVE EVER BEEN OR ARE CURRENTLY LICENSED PERMITTED OR CERTIFIED** as a Physical Therapy Practitioner. Additional pages may be added if necessary. Submit a copy of **Attachment #2** to all such States, counties, or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

List below **ALL** states, counties or provinces in which you hold or have ever held a license, certification or permit as a health professional other than a Physical Therapy Practitioner. Submit a copy of **Attachment #2** to all such states, countries or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

		Yes	No
1.	Have you ever applied for a Physical Therapy license in Tennessee? ( ) Assistant ( ) Therapist	____	____
2.	Have you ever taken the PES or ASI National Physical Therapy Examination (NPTE) for (circle one) Physical Therapist or Physical Therapist Assistant?		
	If yes, please give dates on which the exam was taken _____	____	____
3.	Are you currently scheduled to take the PES NPTE in any other state?		
	If yes, please list state in which you are scheduled to take the NPTE _____	____	____
4.	Have you ever failed the NPTE? If yes, how many times _____	____	____

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the **affirmative**, attach an explanation on a separate sheet. ***In support of your explanation, the final documents or orders from the issuing states, courts, or agencies must be submitted along with this application.***

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:

   a. The cognitive capacity to make appropriate clinical diagnosis (if necessary) and exercise reasoned judgments and to learn and keep abreast of developments in your profession; and

   b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devises, such as voice amplifiers; and

   c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. **"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopaedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

3. **"Chemical substances"** is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

4. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee, or within the past two (2) years.

5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS:	**YES**	**NO**
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?	____	____
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?	____	____
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field or practice, the setting or the manner in which you have chosen to practice?	____	____

[If you receive such ongoing treatment or participate in such a monitoring program, the Committee will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license or certificate should be issued, whether conditions should be imposed or whether you are not eligible for licensure or certification.]

COMPETENCY INFORMATION CONTINUED

QUESTIONS:		YES	NO
2.	Do you currently use chemical substances?		
	a. If yes, do they in any way impair or limit your ability to practice your profession with reasonable skill and safety?		
3.	Are you currently engaged in the illegal use of controlled substances?		
	a. If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?		
4.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?		
5.	If you have ever held or applied for a license or certificate to practice Physical Therapy in any state, country or province, has it been or was it ever denied, reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?		
6.	If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited or otherwise disciplined or voluntarily surrendered under threat or restriction or disciplinary action?		
7.	Have you ever failed a Physical Therapy licensure examination?		
8.	Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?		
9.	Have you ever been rejected or censured by a professional society?		
10.	In relation to the performance of your professional services in any profession:		
	a. Have you ever had a final judgment rendered against you; or		
	b. Have you ever had settlement of any legal action rendered against you; or		
	c. Are there any legal actions pending against you or to which you are a party?		
11.	If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?		

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I, _____, of _____, being duly sworn and identified as
(Applicant's Name) (City) (State)
the person referred to in this application, attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the rules and regulations which were enclosed in the application packet and agree to abide by the them in the practice of Physical Therapy in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Committee and Board may find necessary which may include a full Board or Committee interview.

RELEASE to the Committee and Board, its staff and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice Physical Therapy.

AUTHORIZE the Committee and Board, its staff and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications;

RELEASE from liability the Committee and Board, its staff and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character and other qualifications for certification.

ACKNOWLEDGE that I, as an applicant for certification, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications and for resolving any doubts about such qualifications.

In order to comply with federal statutes, the Board of Occupational and Physical Therapy Examiners is obligated to inform each applicant or licensee from whom it requests a social security number that disclosing such number is mandatory in order for this Board to comply with the requirements of the federal Healthcare Integrity and Protection Data Bank and/or the National Practitioner Data Bank. If the Board is required to make a report about one of its applicants or licensee to either or both of these data banks, it must report that individual's social security number. This application will not be complete if the social security number is omitted. The number will be used for identification purposes and for such other purposes as are allowed by state and federal law.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____

SIGNATURE **DATE**

Sworn to before me, this _____ day of _____ 20_____.

_____

NOTARY PUBLIC Affix Seal Here

My Commission Expires _____

Attachment 1

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 French Landing, Suite 300
Heritage Place Metro Center
NASHVILLE, TENNESSEE 37243

COMMITTEE OF PHYSICAL THERAPY
(615) 532-3202
OR
1-800-778-4123

EDUCATION VERIFICATION

APPLICANT: Supply the information requested in this box and then mail this entire form to the school at which you completed your physical therapy educational program. **NOTE:** Most schools require a fee, so you may want to contact the institution before mailing this form so that you can attach their fee.

TO WHOM IT MAY CONCERN:

I am applying for a certificate or permit to practice physical therapy in the State of Tennessee. The Committee of Physical Therapy requires verification of educational attainment. Please forward an original transcript showing degree awarded and bearing the institution's official seal to the Committee's address below.

Applicant's Full Name _____
(Last) (First) (Middle/Maiden)

Applicant's Address: _____
_____
_____
_____

Applicant's Social Security Number: _____ - _____ - _____

Applicant's Student Identified Number: _____

Year of Graduation: _____

Degree Conferred: _____ Date Degree Conferred: _____

Please forward an original graduate transcript bearing the institution's official seal to the address above.

Thank you for your cooperation and prompt response.

_____ _____
Applicant's Signature Date

Attachment 2

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 French Landing, Suite 300
Heritage Place Metro Center
NASHVILLE, TENNESSEE 37243

COMMITTEE OF PHYSICAL THERAPY
(615) 532-3202
OR
1-800-778-4123

VERIFICATION FROM OTHER STATE CERTIFICATION BOARDS

APPLICANT: Please provide the information requested in the top box and then mail one form to the certification board in EACH state where you **hold or have ever held** a certificate/license/permit to practice any profession. (Copies of this form can be used.) **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish the contact the applicable state(s).

To Be Completed By Applicant (Please Print In Ink)

I, the undersigned applicant, was granted a **(circle one)** license/certificate/permit to practice _____
(Profession)
with **(check one)** License / Certificate / Permit number _____ on _____
(Date)
in the State of _____. The Tennessee Committee of Physical Therapy requests that I submit evidence of the current status of that license in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Committee of Physical Therapy.

Date: _____

_____
Applicant's Signature

_____
Applicant typed or printed name

To Be Completed By Administrative Office of State Certification Board

Name In Full As It Appears On License/Certificate or Permit:

_____
(First) (M.I.) (Last)

License/Certificate/Permit Number: _____ Profession: _____

Date Issued: _____ Date of Expiration: _____

Basis of issuance: _____ Endorsement/Reciprocity with _____
(Check One) (State)
_____ Written Examination _____
(Name of Exam)

The License is currently active and registered? ____ Yes ____ No

Is there any derogatory information on file? ____ Yes ____ No If yes, Please attach supporting documentation.

_____ _____ _____
Authorized Signature Title Date

PH-3124
Rev. 02/04

RDA S836-1

FEE SCHEDULE FOR THE COMMITTEE OF PHYSICAL THERAPY

CHECK METHOD OF APPLICATION

PHYSICAL THERAPIST

PT	By examination: (Total fee due $160.00)	
$100.00	APPLICATION FEE	09-001
$ 50.00	LICENSE FEE	09-001
$ 10.00	STATE REGULATORY FEE	09-006

PT	By Reciprocity: (Total fee due $260.00)	
$100.00	APPLICATION FEE	09-001
$100.00	RECIPROCITY FEE	09-001
$ 50.00	LICENSE FEE	09-001
$ 10.00	STATE REGULATORY FEE	09-006

NAME OF APPLICANT: _____

(PLEASE PRINT)

ATTACH CHECK OR MONEY ORDER PAYABLE TO **STATE OF TENNESSEE** TO THIS PAGE AND ATTACH THIS PAGE TO THE FRONT OF THE APPLICATION IF APPLYING AS AN **PHYSICAL THERAPIST**.

FEE SCHEDULE FOR THE COMMITTEE OF PHYSICAL THERAPY
CHECK METHOD OF APPLICATION

PHYSICAL THERAPY ASSISTANT

PTA	By examination: (Total fee due $135.00)	
$ 75.00	APPLICATION FEE	25-001
$ 50.00	LICENSE FEE	25-001
$ 10.00	STATE REGULATORY FEE	25-006

PTA	By Reciprocity: (Total fee due $235.00)	
$ 75.00	APPLICATION FEE	25-001
$100.00	RECIPROCITY FEE	25-001
$ 50.00	LICENSE FEE	25-001
$ 10.00	STATE REGULATORY FEE	25-006

NAME OF APPLICANT: _____
(PLEASE PRINT)

ATTACH CHECK OR MONEY ORDER PAYABLE TO **STATE OF TENNESSEE** TO THIS PAGE AND ATTACH THIS PAGE TO THE FRONT OF THE APPLICATION IF APPLYING AS A **PHYSICAL THERAPY ASSISTANT**.

LP/G5026303/PT

TENNESSEE DEPARTMENT OF

HEALTH

MANDATORY

PRACTITIONER

PROFILE QUESTIONNAIRE

PURSUANT TO TENNESSEE CODE ANNOTATED SECTION 63-51-101 et seq, LAWS OF TENNESSEE

FOR

LICENSED HEALTH CARE PROVIDERS

FOREWORD

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. § 63-51-101 et seq, requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health. The information specified in the law is contained in the attached questionnaire. From the information submitted, the Department will compile a practitioner profile which is required to be made available to the public via the World Wide Web and toll-free telephone line after May 1, 1999. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information constitutes a ground for disciplinary action against your license. A blank copy of the profile may be obtained from the following web site address: http://tennessee.gov/health**.**

On the department's homepage, under Licensing, click on "Health Professional Boards"; then select the appropriate board.

TABLE OF CONTENTS

SECTION I: GENERAL INSTRUCTIONS

- **Read all instructions thoroughly before completing the profile questionnaire. Incomplete or omitted information may delay meeting the mandatory reporting requirement.**
- **Incomplete or illegible profiles will be returned to the provider for resubmission.**
- **Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **Provide only information for the previous ten (10) years where indicated on the questionnaire.**
- **Complete the questionnaire and attachments by typing or printing your response in block letters in ballpoint pen. Incomplete or illegible profiles will be returned to the provider for resubmission. Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **DO NOT RETURN THESE INSTRUCTIONS WITH THE QUESTIONNAIRE TO THE DEPARTMENT.**
- **You may have completed a similar questionnaire for another state's licensing board. If so, Tennessee law still requires you to complete and submit this form.**
- **If you have an active Tennessee license you are required to complete the questionnaire. This includes those practitioners who are retired or no longer practicing.**

- **Mail the completed ORIGINAL profile questionnaire <u>within thirty (30) days of its receipt by the provider</u> to:**

Healthcare Provider Information Manager
Tennessee Department of Health
Division of Health Related Boards
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243
1-800-778-4123
Local - (615) 532-3202

- **<u>Keep a copy of the questionnaire for your records.</u>**

✓CHECKLIST

Before you mail your questionnaire:

- ☐ Have all questionnaire and supplemental pages been completed with the name of the practitioner, profession and license number at the top of the page?

- ☐ Have supplemental pages been clearly labeled with the corresponding question for which the response is being provided?

- ☐ Have you retained a copy of your signed questionnaire?

SECTION II:

COMPLETING THE PROFILE QUESTIONNAIRE

QUESTIONNAIRE DEADLINE

The provider must submit the questionnaire on or before thirty (30) days from its receipt.

COMPLETING THE FORMS

Complete all forms by printing neatly in block letters in ballpoint pen or typing the information. If a question does not apply to you, indicate so by checking the "Does not apply" box. **Illegible questionnaires will be returned.**

The following numbered parts correspond to the matching number on the questionnaire form.

I. PRACTITIONER DATA

Complete part one (1) noting the following:

- License number: Fill in your license number and indicate your profession in the space provided.
- Social security number: **Your social security number will not be published or in any way given out to the public. It is required for in-house tracking purposes only.**
- Address: Complete mailing and practice address (if applicable). Retirees: Write in "N/A" for practice address.

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

List chronologically all medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

III. SPECIALTY BOARD CERTIFICATIONS

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association or any other specialty certifying body as determined by your Tennessee licensing board.

IV. FACULTY APPOINTMENTS

Answer ALL yes/no questions with a “yes” or “no” response. A brief statement in the space provided should follow a "yes" answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

V. STAFF PRIVILEGES

List all hospitals at which you hold staff privileges. This includes:

- Licensed hospitals-this term is defined at T.C.A. § 68-11-201.

In the spaces provided, answer information about the TennCare plans in which you participate, if any. If there are more than five (5), please send attachment.

VI. FINAL DISCIPLINARY ACTION

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal’s period expired, or that the applicable board issued an agreed order or consent decree.

In the “Description of Violation” spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sex related, impairment, fraud, etc.

In the “Description of Action” spaces, indicate the type of disciplinary action imposed against your professional license.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer “yes” to any of the questions in this section and if the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of

disposition immediately after the appeal is disposed of by the adjudicating authority. Please read questions VII B and C in their entirety before answering those questions.

VII. CRIMINAL OFFENSES

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice of a profession within the most recent ten (10) years. If you answer "yes" to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

VIII. LIABILITY CLAIMS

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19,1998, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE THRESHOLD AMOUNT ESTABLISHED BY YOUR TENNESSEE LICENSING BOARD ARE NOT REQUIRED TO BE SUBMITTED. To find out the threshold amount established by your board, consult your board's web page at www.state.tn.us/health/ or call 1-800-778-4123. Pending malpractice claims are not required to be reported unless/until final adjudication against you.

IX. OPTIONAL INFORMATION

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required.

Practitioner's Name _____ **License #** _____
Profession _____

SECTION III:

HEALTHCARE PROVIDER INFORMATION MANAGER
TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TENNESSEE 37243

I. PRACTITIONER DATA

A. PROFESSIONAL LICENSE NUMBER: _____ PROFESSION: _____

B. SOCIAL SECURITY NUMBER: _____ (**This will not be published as part of the profile or website).**

C. NAME (INCLUDE MAIDEN AND ON 2ND/3RD LINES ANY ALIASES, IF APPLICABLE):
CURRENT NAME:

_____
(LAST) (FIRST) (MIDDLE AND MAIDEN NAME) (IF APPLICABLE)

FORMER NAME(S):

_____
(LAST) (FIRST) (MIDDLE)

_____
(LAST) (FIRST) (MIDDLE)

D. MAILING ADDRESS:

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

PRIMARY PRACTICE ADDRESS: (This will be published as part of the profile and the web site).

_____
(PRACTICE NAME)

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

E. TELEPHONE:(_____)_____**(This will not be published as part of the profile or the web site).**

F. LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English or translation services that may be available at your primary practice location.

1. _____
2. _____

G. SUPERVISING PHYSICIAN: If you are required by law to be supervised by a physician (physician assistant or nurse practitioner) indicate the name(s) and address(es) of each supervising physician. If you need more space, attach additional sheets:

1. _____
2. _____

Practitioner's Name _____ **License #** _____
Profession _____

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: T.C.A. §63-51-105(a)(6) and (7))

PROGRAM/INSTITUTION	CITY/STATE/ COUNTRY	DATE OF GRADUATION	TYPE OF DEGREE
1.			
2.			
3.			
4.			
5.			
6.			

B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal. (Authority: T.C.A. § 63-51-105(a)(6))

PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY,STATE, COUNTRY)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.			
2.			
3.			
4.			

Practitioner's Name _____ **License #** _____
Profession _____

III. SPECIALTY BOARD CERTIFICATIONS

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) (Authority: T.C.A. § 63-51-105(a)(8)) If "Yes", complete section below. YES ❒ NO ❒

CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1.	
2.	
3.	
4.	
5.	

IV. FACULTY APPOINTMENTS

A. Have you had the responsibility for graduate medical education within the last ten (10) years? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

If "YES", list the title of the appointment and name(s) and city/state of institution(s). (Attach additional sheets, clearly labeled with this question number, if necessary.)

	TITLE	INSTITUTION	CITY/STATE
1.			
2.			
3.			
4.			

V. STAFF PRIVILEGES

A. Do you currently hold staff privileges at a hospital? (Authority: T.C.A. §63-51-105(a)(a)) YES ❒ NO ❒

If "YES", list each hospital at which you currently have staff privileges: (Attach additional sheets, clearly labeled with this question number, if necessary)

	Name of Hospital	City/State
1.		
2.		
3.		
4.		
5.		

Practitioner's Name _____ **License #** _____
Profession _____

B. Do you currently participate in any TennCare plan? (Authority: T.C.A. § 63-51-105(a)(16)) YES ❒ NO ❒
If "YES", list each plan in which you currently participate:

Name of TennCare Plan
1.
2.
3.
4.
5.

VI. FINAL DISCIPLINARY ACTION (See Instructions)

A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: T.C.A. § 63-51-105(a)(8)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)

	AGENCY NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name_____ **License #**_____
Profession _____

B. Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted for reasons related to competence or character by the hospital's governing body? (Authority: T.C.A. § 63-15-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) medical institution(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

C. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by <u>any</u> hospital in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: T.C.A. § 63-51-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF ACTION
1.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.			

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name_____ **License#**_____
Profession _____

VII. CRIMINAL OFFENSES (See Instructions)

Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: T.C.A. § 63-15-105(a)(1))

If "YES" briefly describe the offense(s): YES ❒ NO ❒

	DESCRIPTION OF OFFENSE	DATE	JURISDICTION
1.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒
2.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒
3.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒

VIII. LIABILITY CLAIMS

Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998? (Authority: T.C.A. §63-51-105(a)(5)) If "YES", indicate the date of claim(s) and the amount of judgment(s), award(s) or settlement(s).

	ENTRY DATE OF DISPOSITION ORDER OR SETTLEMENT	AMOUNT
1.		
2.		
3.		

IX. OPTIONAL INFORMATION

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature: (optional) (Authority: T.C.A. § 63-15-105(a)(11))

	TITLE	PUBLICATION	DATE
1.			
2.			
3.			
4.			

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES AWARDS: List any information regarding professional or community service associates, activities and awards: (optional) (Authority: T.C.A. § 63-15-105(a)(12))

	COMMUNITY SERVICE/AWARD/HONOR	**ORGANIZATION**
1.		
2.		
3.		
4.		

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. § 63-51-113 and/or 63-51-118.

_____ Date:_____
(Signature of Provider)

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